CLAIM FILING INSTRUCTIONS

READ CAREFULLY BEFORE COMPLETING THE PROOF OF CLAIM FORM

This Proof of Claim form is to be used if you have a claim against the receivership estate of the Vesta Fire Insurance Corporation or its' affiliates, Shelby Casualty Insurance Company, The Shelby Insurance Company, Texas Select Lloyds Insurance Company, or Select Insurance Services, Inc., (collectively referred to as the "Vesta Receiverships.") By accurately completing this form you can protect your interests, help us identify your claim and allow us the opportunity to properly consider your claim. ***Do not use this form to file a claim with a guaranty association. Please contact the guaranty association in your state to obtain information about filing a claim with the guaranty association responsible for your claim, if any. It is very important that you complete all the sections applicable to you, sign, and return the form.***

THE DEADLINE FOR FILING YOUR PROOF OF CLAIM IS 11:59P.M. C.S.T., NOVEMBER 30, 2007

IF YOU HAVE PREVIOUSLY FILED A PROOF OF CLAIM WITH THE SPECIAL DEPUTY RECEIVER, NO FURTHER CLAIM FILING WILL BE REQUIRED.

Please be aware that by filing a proof of claim, you are waiving any right to pursue the personal assets of the insured to the extent of the coverage or policy limits provided by the Vesta Receiverships. And, by filing a proof of claim, you agree that, to the extent of coverage and policy limits provided, you will seek satisfaction of the claim against the insured solely from distributions paid by the liquidator on the claim and from any guaranty association.

Please follow these instructions in completing the Proof of Claim form:

1. Please check the box of the correct insurance company receivership estate you have a claim against.

2. Provide us with your full name, permanent address, phone number, and, if you have computer access, your e-mail address. During the course of the receivership proceedings, you must notify us in writing of any mailing address and telephone number change. Failure to provide us with any change in your address may cause your claim to be delayed or disallowed.

3. You must provide your social security numbers (or Tax ID number) and telephone numbers, and sign and date the Proof of Claim. Claims filed by corporations must be signed by an authorized representative, stating the capacity of the signatory. If an attorney is signing this form on behalf of a client, a power of attorney must be attached.

4. If you have assigned your right of recovery, or if you have received your assignment, you must indicate the assignee's name and address and attach a copy of the assignment.

5. Indicate the type of claim and amount, if known, by checking the appropriate category and indicating the amount. If the amount of a claim is unknown, insert the word "unstated" in the amount column.

6. **YOU MUST INCLUDE ANY DOCUMENTATION SUPPORTING YOUR CLAIM.** If you fail to adequately describe or document your claim, your claim may be disallowed.

7. To reduce expenses, receipt of the Proof of Claim form by the Special Deputy Receiver will not be acknowledged. You will receive notice at the address you have provided to us on the Proof of Claim form when your claim is processed.

8. You must disclose all deposits, cash, premiums, securities, trust funds, letters of credit, or other assets of the Vesta Receiverships that you hold or control. If you were an agent, you need to submit an accounting of all premiums collected and held at the time we ceased writing policies.

9. After you complete the Proof of Claim form, review the completed form, sign, and date it. Failure to properly complete the Proof of Claim form according to these instructions may cause your claim to be delayed or disallowed.

IMPORTANT NOTICE
MAIL THE COMPLETED AND SIGNED FORM AND ALL OF YOUR DOCUMENTATION TO:
THE VESTA RECEIVERSHIPS
P.O. Box 1133, Dripping Springs, Texas 78620-1133
Contact Number: 1-512-894-3705
For more information go to http://www.sdrtx.com

POC NO.: _____ (To Be Completed by SDR)

DATE RECEIVED: _____ (To Be Completed by SDR)

PROOF OF CLAIM

THE DEADLINE FOR FILING YOUR PROOF OF CLAIM IS 11:59P.M. C.S.T., NOVEMBER 30, 2007

☐ **VESTA FIRE INSURANCE CORPORATION IN RECEIVERSHIP**
☐ **SHELBY CASUALTY INSURANCE COMPANY IN RECEIVERSHIP**
☐ **THE SHELBY INSURANCE COMPANY IN RECEIVERSHIP**
☐ **TEXAS SELECT LLOYDS INSURANCE COMPANY IN RECEIVERSHIP**
☐ **SELECT INSURANCE SERVICES, INC. IN RECEIVERSHIP**
(Collectively referred to as the "Vesta Receiverships")

PLEASE PRINT

Claimant's Name: _____

Street Address: _____

_____
City State Zip

Phone: _____ Fax: _____

E-Mail Address: _____ DOB: _____

Social Security No. or Tax ID No.:_____

Provide us with the name, address and phone number of someone who will always know how to contact you:

Name: _____

_____
Address City State Zip

Phone Number: _____ E-Mail: _____

(If represented by an attorney, please complete this section)

Name of Attorney: _____

Name of Law Firm:_____

Attorney File No.: _____

Street Address: _____

_____
City State Zip

E-Mail Address: _____

Phone: _____ Fax:_____

Tax ID No.: _____

POLICY NO. _____

CLAIM NO. _____

Note: Attach a Copy of Power of Attorney

You must notify us of any change in the above addresses or phone numbers.

Claim is for (check the appropriate box below): **Claim Amount:**

☐ Payments made or expenses incurred by a Guaranty Association in paying covered claims.....$_____
☐ Claim, cost of defense, or expense under a policy of insurance not covered by a Guaranty Association ….....$_____
☐ Return of premium under a policy of insurance not covered by a Guaranty Association.....$_____
☐ Unpaid pre-receivership policy costs such as fees to attorney or other professional services.....$_____
☐ Unpaid fees for goods and services to vendors ……$_____
☐ Unpaid commissions or invoices to agents or brokers.....$_____
☐ Reinsurance (Facultative ☐ Assumed ☐ Ceded ☐ Premium ☐ …check one).....$_____
Broker:_____Type of Business:_____Underwriting Years:_____
☐ Insurance company claim for subrogation ☐ contributions ☐ indemnity ☐ ….....$_____
☐ Amounts due a governmental entity (city ☐ county ☐ state ☐ Federal ☐).....$_____
☐ Other claim.....$_____
TOTAL AMOUNT OF CLAIM (If the amount is unknown insert the word unstated")…… $_____

Describe the nature of your claim:_____

_____

_____

_____

Date of loss: _____ Residency at time of loss: _____

If you have an assignment of benefits, provide assignors name and address below and attach copy of the assignment:

f

_____

_____

If you have assigned any part of your right of recovery, provide assignee's name and address below and attach copy of the assignment:

_____

_____

If you hold or exercise any control over any cash, securities, trust funds, letters of credit or other assets of the Vesta Receiverships provide description and location of asset:_____

_____

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_____

POC NO.: _____
(To Be Completed by SDR)

DATE RECEIVED: _____
(To Be Completed by SDR)

If you received any payments on your claim, provide the name of who paid you and the amount of payment:

_____

_____

Is there any other insurance available to cover your claim? Yes ☐ No ☐

If the Answer is "yes", what is the name of the insurance company? _____
Contact Person: _____ Phone No.: _____

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM

AFFIRMATION OF CLAIMANT

I, _____ affirm that I have read the foregoing Proof of Claim and understand the contents thereof, that this claim of $_____ against the Vesta Receiverships is justly owing to me, that I alone am entitled to file this claim, except as stated above, that there is no setoff to the claim thereto, except as stated above, that the matters set forth above and any accompanying statements and documents are true to my own knowledge, and that no payment of or on account of the aforesaid claim has been made, except as stated.

By signing this Proof of Claim form claimant understands that all or some of the information on this form will be used in approving the Proof of Claim and obtaining court approval. Claimant hereby authorizes the Vesta Receiverships, its affiliates or representatives or agents to disclose, discuss, and/or release, orally or in writing, information contained in this Proof of Claim form. Claimant agrees to cooperate in signing additional release forms, if any.

CLAIMANT UNDERSTANDS THAT BY FILING THIS CLAIM IN THE ESTATE OF THE INSURER CLAIMANT IS WAIVING ANY RIGHT TO PURSUE THE PERSONAL ASSETS OF THE INSURED TO THE EXTENT THAT THERE ARE POLICY LIMITS OR COVERAGE PROVIDED BY THE VESTA RECEIVERSHIPS

_____ _____
DATE SIGNED SIGNATURE OF PERSON MAKING CLAIM

_____ _____
TITLE (IF APPLICABLE) PRINTED NAME

If someone other than the person making the claim has completed this form, please provide the following information:

Date: _____ Name: _____
Address: _____ Relationship to Claimant: _____

_____ _____
Phone Number Signature of Person Completing the Form for the Claimant

IMPORTANT NOTICE
RETURN THE COMPLETED POC AND REQUESTED DOCUMENTATION TO:
VESTA RECEIVERSHIPS
P.O. Box 1133, DRIPPING SPRINGS, TEXAS 78620-1133
CONTACT NUMBER: 1-512-894-3705

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